Attachment A

The Boeing Company

Active Employees Represented by the International Association of Machinists and Aerospace Workers, AFL-CIO, Local No. 18 and Local No. 2340

Group Benefits Package

- Weekly Disability Plan
- Basic Life Insurance Plan
- Accidental Death and Dismemberment Plan
- Medical Plans
- Network Dental Plan

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THE PACKAGE

The package includes:

Weekly Disability Plan

Basic Life Insurance Plan

Accidental Death and Dismemberment Plan

Medical Plans

Network Dental Plan

Section 1. Eligible Employees

Employees eligible for the package are active hourly represented employees of The Boeing Company, ("the Company") by the International Association of Machinists and Aerospace Workers, AFL-CIO, Local Lodge No. 18 and Local Lodge No. 2340, T-45 Program. The employee is not eligible to enroll if he or she is working in a capacity that, at the sole discretion of the *Plan administrator,* is considered contract labor or independent contracting.

Section 2. Eligible Dependents

Dependents eligible for the medical and dental plans are the employee's legal spouse and children (natural children, adopted children, children legally placed with the employee for adoption, and stepchildren) who are under age 25, unmarried, and dependent on the employee for principal support, including children who are attending school.

An employee may request coverage for the following dependents:

1. A common-law spouse if the relationship meets the common-law requirements for the state in which the employee entered into the common-law relationship. (A domestic partner is not considered an eligible spouse.)
2. Other children, as follows, who are under age 25, unmarried, and dependent on the employee for *principal support*, including children who are attending school:
   a. Children who are related to the employee either directly or through marriage (e.g., grandchildren, nieces, nephews).
   b. Children for whom the employee has legal custody or guardianship or has a pending application for legal custody or guardianship and are living with the employee.

Annual certification of eligibility is required to continue coverage from age 19 through age 24.

In accordance with federal law, the Company also provides medical and dental coverage to certain dependent children (called alternate recipients) if the Company is directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction.

Documentation is required to request coverage for a child named in a QMCSO or a child for whom the employee has legal custody or guardianship.

A. Special Provisions When Family Members Are Boeing Employees

No person may be covered both as an employee (active or retired) and as a dependent under any type of plan offered by the Company, and no person will be considered a dependent of more than one employee. Eligible dependents do not include other Boeing employees covered under any *Company-sponsored plan* providing medical, vision care, prescription drug, dental, or similar services. However, if a dependent spouse also is a part-time Boeing employee, the spouse and eligible dependent children are considered eligible dependents if other Boeing coverage is waived. If the employee and spouse both are Boeing employees and have dependent children, the parents may elect medical and dental coverage for eligible children under one parent's plans. In addition, all eligible children must be enrolled in the same medical plan and the same dental plan (except as required by a QMCSO).

B. Incapacitated Children

A disabled child age 25 or older may continue to be eligible (or enrolled if the employee is a newly eligible employee) if he or she is incapable of self-support due to any mental or physical condition that began before age 25. The child must be unmarried and dependent on

the employee for *principal support.* Coverage may continue under the medical and dental plans for the duration of the incapacity as long as the employee continues to be eligible under the plans and the child continues to meet these eligibility requirements.

Special applications for coverage are required for disabled dependent children age 25 or older.

Section 3. How to Enroll

A. Disability, Life, and Accident Plans

Employees automatically are enrolled in the Weekly Disability Plan, Basic Life Insurance Plan, and Accidental Death and Dismemberment Plan when eligible. A Beneficiary Designation form is provided to the employee for completion.

B. Medical Plans

In designated locations, the Company provides employees with a choice among medical plans. The Traditional Medical Plan offers enhanced benefits when a member of its *network* is used. Health maintenance organizations (HMOs) also rely on selected networks of providers.

Employees receive enrollment instructions at the time of employment and may elect medical coverage under one medical plan during the first 31 days of employment. All family members, including the employee, must be enrolled in the same medical plan, except as specified in Section 2.A.

The Company provides medical coverage as follows:

1. Employees may enroll in the Traditional Medical Plan; employees who live in an HMO service area may enroll in an HMO instead of the Traditional Medical Plan.
2. An employee may waive medical coverage for himself/herself and eligible dependents.
3. Each employee with a spouse must provide information regarding coverage available through another employer to determine whether or not special contributions are required to enroll the spouse. If the employee does not authorize a required contribution, the spouse will not be enrolled for medical coverage. The employee will not be able to enroll the spouse until the earlier of:
   a. The next annual enrollment period.
   b. The date the spouse loses the option to be covered under the other employer-sponsored medical plan.

The Company will require periodic verification of pertinent information.

C. Network Dental Plan

The Company offers coverage under the Network Dental Plan to employees and eligible dependents. Employees receive enrollment instructions at the time of employment and may elect dental coverage under the Network Dental Plan during the first 31 days of employment. An employee may waive coverage for himself/herself and eligible dependents.

D. Annual Enrollment Period

The Company establishes an annual enrollment period when employees may change medical plans or elect or drop medical and/or dental coverage for themselves and eligible dependents.

E. Special Enrollment

If an employee declines dependent enrollment in the medical and dental plans because of other employer-sponsored health care coverage (such as through a spouse's employer), the employee may be able to enroll eligible dependents in the Company-sponsored medical and dental plans during the year as long as enrollment is within 60 days after other coverage ends.

If an employee declines dependent enrollment when first eligible and the dependent's other health care coverage was through continuation coverage from a previous employer (coverage mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA), the dependent must exhaust his or her COBRA coverage to be eligible for the special enrollment period.

If a dependent's other health care coverage was not through COBRA, the coverage loss must be due to loss of eligibility for the health care coverage (including from divorce, death, termination of employment, or reduction in hours of employment) or termination of employer contributions toward such coverage.

If an employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may enroll the new dependent during the year as long as enrollment is requested within 120 days after the qualified event. See "Changes in Status" for more information.

F. Changes in Status

The employee will not be able to make enrollment changes until the next annual enrollment period unless he or she experiences one of the qualified changes in status described in this section. Any change in enrollment must be consistent with the change in status. To be consistent, the event must cause the employee or a family member to gain or lose eligibility for Company-sponsored health care coverage or health care coverage sponsored by a spouse's or dependent child's employer, and the election change must be on account of and correspond with the employee's or family member's gain or loss of eligibility. Qualified changes in status include the following:

1. The employee marries, divorces, or becomes legally separated, or the marriage is annulled.
2. The employee acquires a new, eligible dependent child, such as by birth, adoption, or placement for adoption.
3. The employee's spouse or dependent child dies.
4. The employee, spouse, or dependent child starts or stops working.
5. The employee, spouse, or dependent child has any other change in employment status that affects eligibility for coverage such as changing from full time to part time (or part time to full time), salaried to hourly (or hourly to salaried), strike or lockout, or beginning or returning from a leave of absence.
6. The employee, spouse, or dependent child experiences a significant increase in the cost of employer-sponsored health care coverage or the employer-sponsored health care coverage ends, including expiration of COBRA coverage.
7. The employee, spouse, or dependent child experiences a significant curtailment or cessation of employer-sponsored health care coverage.
8. The employee, spouse, or dependent child becomes eligible or ineligible for Medicare or Medicaid.
9. The employee's dependent child becomes eligible for, or no longer is eligible for, health care coverage due to age limits, student status, or a similar eligibility requirement.

10. The employee's spouse or dependent child makes an enrollment change in his or her employer-sponsored health care coverage, either because of a qualified change in status or an annual enrollment.
11. The employee, spouse, or dependent child changes place of residence or work, affecting access to care within the current plan.
12. The employee is transferred to a different division, affecting his or her eligibility for benefits under Company-sponsored health care plans.

The employee also may change elections to comply with a qualified medical child support order (QMCSO) to provide or cancel coverage for the employee's child resulting from a divorce, annulment, or change in legal custody.

In most situations, the employee must request enrollment within 60 days after the qualified event. An employee can enroll a new dependent within 120 days following the employee's marriage or a dependent child's birth, adoption, or placement for adoption. To request enrollment for a new dependent, the employee must call the People Office. The employee must provide the People Office with any required supporting documentation within 31 days of the date the enrollment is requested or the coverage change request will be denied.

If the employee is enrolled in an HMO and moves out of the service area, the employee can enroll in the Traditional Medical Plan by calling the People Office.

Section 4. Effective Date of Coverage

A. Employees

For newly hired employees, the package becomes effective as follows:

1. Weekly disability, life insurance, and accidental death and dismemberment coverage becomes effective on the first day of the month following one full calendar month of continuous employment, provided the employee is *actively at work* on that date.
2. Medical and dental coverage becomes effective on the first day of the month following one full calendar month of continuous employment.

To complete a full calendar month of employment, the employee must be on the active payroll from the first through the last regularly scheduled Company workday during that calendar month. Thereafter, to be an eligible employee in any calendar month, the employee must be on the active payroll on the first day of that month.

For coverage during a leave of absence, see Section 17.

In all cases, the employee must authorize required contributions.

B. Dependents

Current eligible dependents are covered for medical and dental benefits on the same date the employee's coverage is effective. Eligible dependents acquired after the employee's coverage is effective become covered on the date of marriage, date of birth, date the child is legally placed with the employee for adoption, if application is made within 120 days of the event. For other newly eligible dependents, coverage is effective on the date dependency is established, if application is made within 60 days of the event.

The employee authorizes required contributions when enrolling eligible dependents.

Section 5. Company and Employee Contributions

Company and employee contributions for the Group Benefits Package are described in the Group Benefits Article in the Collective Bargaining Agreement.

Section 6. Weekly Disability Plan

Employees who become *totally disabled* as a result of a nonoccupational accidental injury or illness, including a pregnancy-related condition, while covered under the Weekly Disability Plan are eligible for a weekly benefit.

A. Benefits

Following the waiting period (if any), the employee receives a weekly benefit based on the employee's *weekly base salary*, according to the schedule of benefits below.

Weekly Disability Benefit Schedule

In the Event of:	Benefits Begin on the:	Benefit Amount:	For a Maximum Period of:
An accidental injury	1st day of disability	60% of *weekly base salary*, to a maximum of $315	26 weeks
A hospital confinement	1st day of disability	60% of *weekly base salary*, to a maximum of $315	26 weeks
An illness, including pregnancy-related conditions	4th day of disability	60% of *weekly base salary*, to a maximum of $315	26 weeks

Note: If the employee is absent for a period of four or more consecutive days due to a disability resulting from an outpatient surgery in a hospital or surgical facility, benefits will be retroactive to the first day of such disability.

Benefits under the Weekly Disability Plan are determined using the *weekly base salary* reflected in People Office records when the disability first begins. For part-time employees, weekly disability benefits are determined using the average *weekly base salary* actually earned for the six weeks immediately preceding the date of disability. There is no minimum benefit payment under the Weekly Disability Plan.

For employees *actively at work* whose *weekly base salary* either increases or decreases, the coverage amount (the weekly benefit for which the employee may be eligible) automatically changes on the first of the month following or coinciding with the date the People Office is notified of the change in salary. For employees who are not *actively at work* on the day the coverage change is to become effective, the effective date of the new coverage amount is delayed until the first of the month following or coinciding with the day the employee returns to work for one full day. Any retroactive change in *weekly base salary* does not retroactively change the disability coverage amount under this plan. If the period of disability has started, a change in *weekly base salary* does not change the benefit amount.

B. Total Disability

To be eligible for weekly disability benefit payments, the employee must be *totally disabled* and under the continuous care of a legally qualified *physician* throughout the period of *total disability*. *Totally disabled* means both of the following apply to the employee:

- The disability is the result of a nonoccupational accidental injury or illness (including a pregnancy-related condition).
- The accidental injury or illness prevents the employee from performing the material duties of his or her occupation or of other appropriate work the Company makes available.

In addition, the service representative may require the employee to be examined by a physician of its choice as often as reasonably necessary to verify continuous *total disability*.

All determinations of *total disability* are made by the service representative within the terms of its contract with the Company.

C. Benefit Payment Period

Benefits begin as shown in the Weekly Disability Benefit Schedule (Section 6.A) and continue while the employee is disabled, up through the 26th week of disability. Employees must submit a claim to the service representative and meet any waiting period requirements before benefits will be paid. Employees receive any retroactive amounts as soon as the claim is approved.

Employees receive benefit payments as shown in the schedule in Section 6.A while totally disabled. Benefits stop when the employee no longer is disabled, at the end of the maximum benefit period, or at death, whichever occurs first.

1. Separate Periods of Disability

   A period of disability ends and benefit payments under the Weekly Disability Plan stop when the employee no longer is disabled for one full day. If the employee has a second period of disability, the cause of the second disability and the length of recovery time between disability periods will determine whether it is treated as a temporary recovery (a continuation of the first disability claim) or as a separate disability claim.

   Recovery is considered temporary if, within 30 consecutive days of the employee's return to work, the employee is absent as a result of the same or a related disability.

   The following provisions apply to periods of temporary recovery:

   a. No new waiting period (if any) applies.
   b. The *weekly base salary* used to determine initial weekly disability benefits does not change.
   c. No weekly disability benefits are paid for the period of temporary recovery.
   d. The employee may be eligible for any benefits remaining from the original 26-week period.

   The second period of disability is considered a separate disability claim if the employee has returned to work for one full day and one of the following applies:

   a. It is due to a different cause than the first disability period.
   b. It is due to the same cause or causes but the recovery lasted longer than the allowable temporary recovery time limits.
   c. The first period of disability began before the employee was covered under the Weekly Disability Plan.

   The employee must submit a claim to the service representative and meet the waiting period requirements (if any) before benefits will be paid.

D. When an Injury or Illness Is Caused by the Negligence of Another

If a third party is legally liable for an injury or illness to a person covered under the Weekly Disability Plan, regular benefits are paid if the covered person agrees to cooperate with the service representative in administering the plan's subrogation rights. This includes providing all necessary and requested information and submitting bills related to the injury or illness to any applicable party. The covered person also must agree to reimburse the plan if payment is recovered from the liable party or any other source. A third party includes any party possibly responsible for causing or compensating the injury or illness of a person covered under the Weekly Disability Plan, or the covered person's automobile, homeowner's, or other insurance coverage.

E. Exclusions

The Weekly Disability Plan does not cover any disability due to:

1. Occupational injury or illness.
2. Intentionally self-inflicted injury (while sane or insane).
3. Committing, or attempting to commit, an assault, battery, or felony.
4. War or any act of war (declared or not declared). The plan does, however, pay for disabilities caused by an act of war while the employee is traveling on business for the Company.
5. Insurrection, rebellion, or taking part in a riot or civil commotion.
6. Military duty other than temporary active duty of fewer than 31 days.

An employee is not considered disabled, and no benefits are paid for, any day of confinement in a penal or correctional institution for conviction of a crime or other public offense.

Section 7. Basic Life Insurance Plan

The basic life insurance coverage amount equals $23,000. The total amount is payable in the event of the employee's death from any cause at any time or place while covered under the Basic Life Insurance Plan. Payment is made in a lump sum or by issuance of a checkbook to the designated beneficiary. The employee may change beneficiaries at any time by submitting a Beneficiary Designation form to the People Office.

If the employee becomes *totally disabled* while covered under the Basic Life Insurance Plan and before age 60 from any cause, the life insurance benefit will remain in force until the employee recovers. If such a disability begins between ages 60 and 65, coverage will continue until the earlier of the employee's recovery or attainment of age 65. Proof of disability must be furnished within 12 months of the date active work ends. If the employee recovers but does not return to work, all coverage terminates. The employee may then convert the total amount of basic life insurance coverage under the conversion of coverage provision.

An employee who becomes terminally ill while covered under the Basic Life Insurance Plan may request an accelerated death benefit of up to 50 percent of the life insurance benefit with a $5,000 minimum. Upon approval of the request by the service representative, the benefit will be paid in a lump sum. When the request is approved, the amount of life insurance then in effect is reduced by the amount of the accelerated death benefit. After the reduction, an employee cannot apply for an individual conversion policy with respect to the amount of life insurance received as an accelerated death benefit.

Section 8. Accidental Death and Dismemberment Plan

Accidental death and dismemberment benefits are provided if the employee's loss of life, paralysis, or loss of eyesight, speech, or hearing is caused by a covered accident (including an occupational accident) that occurs while the employee is covered under the plan.

A. Benefits

The full principal sum, $23,000, is paid to the beneficiary if the employee dies. This amount is in addition to any amount payable under the group life insurance coverage.

The following benefits are payable if the covered injury causes any of the following losses within 365 days after the covered accident:

Loss	Percentage of Principal Sum
Life	100
Quadriplegia	100
Both Hands or Both Feet	100
Sight of Both Eyes	100
One Hand and One Foot	100
One Hand and the Sight of One Eye	100
One Foot and the Sight of One Eye	100
Speech and Hearing in Both Ears	100
Paraplegia	75
Hemiplegia	50
One Hand or One Foot	50
Sight of One Eye	50
Speech or Hearing in Both Ears	50
Hearing in One Ear	25
Thumb and Index Finger of Same Hand	25

"Loss" of a hand or foot means the complete severance through or above the wrist or ankle joint.

"Loss" of sight of an eye means the total and irrecoverable loss of the entire sight in that eye.

"Loss" of hearing in an ear means the total and irrecoverable loss of the entire ability to hear in that ear.

"Loss" of speech means the total and irrecoverable loss of the entire ability to speak.

"Loss" of a thumb and index finger means the complete severance through or above the metacarpophalangeal joint of both digits.

"Loss" of a limb means the loss of an entire arm or entire leg.

"Quadriplegia" means the complete and irreversible paralysis of both upper and both lower limbs.

"Paraplegia" means the complete and irreversible paralysis of both lower limbs.

"Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.

"Injury" means bodily injury caused by an accident occurring while the employee is covered under the Accidental Death and Dismemberment Plan, and resulting directly and independently of all other causes in death or loss as listed above.

If more than one loss is sustained by the employee as the result of the same accident, no more than 100 percent of the principal sum will be paid.

B. Exposure and Disappearance

If the employee is unavoidably exposed to the elements due to an accident occurring while covered under this plan, and as a result of such exposure suffers a loss for which a benefit is otherwise payable, the loss will be covered under the terms of this plan.

If the employee's body has not been found within one year of the disappearance, forced landing, stranding, sinking, or wrecking of a vehicle in which he or she was an occupant while covered under this plan, the loss will be covered as an accidental death under the terms of the plan.

C. Exclusions

No plan benefits will be paid for a death or loss caused in whole or in part by, or resulting in whole or in part from:

1. Suicide or intentionally self-inflicted injury.
2. Declared or undeclared war or act of declared or undeclared war occurring in the continental limits of the United States, unless it is an act of terrorism.

   "Terrorism" means any violent act that is intended to cause injury, damage, or fear and that is committed by or purportedly committed by one or more individuals or members of an organized group to make a statement of the individual's or group's political or social beliefs, concepts or attitudes, and/or to intimidate a population or government into granting the individual's or group's demands.
3. An illness, sickness, disease, bodily or mental infirmity, medical or surgical treatment, or bacterial or viral infection, regardless of how contracted, except bacterial infection resulting from an accidental cut or wound or accidental food poisoning. However, if a covered loss results from medical or surgical treatment of an injury, benefits are provided for the loss.

Section 9. Medical Plans - Schedule of Benefits

In designated locations, the Company provides employees with a choice among medical plans. The Traditional Medical Plan offers enhanced benefits when a member of its *network* is used. Health maintenance organizations (HMOs) also rely on selected networks of providers. Benefits are subject to all provisions of the selected plan, including medical review requirements, maximum benefits, coordination of benefits, exclusions, and definitions. If an HMO plan does not offer the negotiated plan design, the Company will substitute the closest available plan.

Benefits are provided on a benefit year basis. A benefit year is January 1 through December 31, annually.

A. Preventive Care Services

The following preventive care services are provided according to network guidelines.

1. Routine physical examinations for employees and spouses and routine screening examinations for employees and dependents.

2. Routine child care, including periodic examinations, preventive immunizations, and inoculations as prescribed by a physician.

B. Covered Medical Services and Supplies

The plans provide benefits according to network guidelines for the following medically necessary services and supplies required for the diagnosis and/or therapeutic treatment of a nonoccupational accidental injury or illness or medically necessary treatment of certain listed conditions.

1. Physician services, including office visits, consultation for a second or third opinion, surgery, and hospital visits. Benefits for manipulation of the spine are limited to 26 visits each year, including related services such as an initial examination and initial X-rays.
2. Services provided by other licensed health care professionals.
   a. Diagnostic X-ray and laboratory services.
   b. Physical, occupational, and speech therapy to restore function. Services must be prescribed by a physician.
   c. Neurodevelopmental therapy for children age six or under.
3. Medical equipment, services, and supplies.
   a. Ambulance services.
   b. Hearing aids.
   c. Hemodialysis.
   d. Home medical equipment.
   e. Orthopedic appliances and braces.
   f. Oxygen and anesthesia.
   g. Prostheses.
   h. Radiation therapy (including X-ray therapy) and chemotherapy.
4. Hospital services and supplies, including semiprivate room and board, operating rooms and equipment; surgical dressings and supplies; X-ray and laboratory services; anesthesia, including administration and materials; pathology; drugs; outpatient hospital and emergency room services.
5. Hospital alternatives. Benefits for the following are provided in place of medically necessary hospitalization.
   a. Skilled nursing facilities.
   b. Home health care.
   c. Hospice care.

C. Special Conditions

Services are covered for the following conditions, according to network guidelines.

1. Cosmetic surgery for prompt repair of accidental injury.
2. Mental illness and substance abuse. See Section 10.C.6 and Section 10.C.7.
3. Oral surgery.
4. Pregnancy.
5. Reconstructive breast surgery in connection with a mastectomy.

6. Sterilization (vasectomy and tubal ligation).
7. Temporomandibular joint disease (TMJ) and myofascial pain dysfunction syndrome (MPDS).
8. Transplants.

D. Vision Care

Vision care benefits are provided according to a schedule of benefits.

E. Prescription Drugs

Prescription drug benefit payment levels are described in Section 10.B.3 and Section 10.C.12.

Section 10. Traditional Medical Plan - Payment Provisions

Payment provisions under the Traditional Medical Plan follow.

A. Deductibles

Deductibles are expenses for certain covered services and supplies that the employee or family member must pay before benefits are payable.

Deductibles are subtracted from the total of all other submitted expenses for covered medical services and supplies before benefits are payable. Only expenses covered by the plan may be counted toward accumulation of deductibles.

	Traditional Medical Plan
1. Expenses subject to deductibles	
a. *Network providers*	All covered expenses (except those for *network provider* office visits where the $10 office visit copayment applies, preventive care, vision care, and mail service prescription drugs) are subject to deductibles.
b. Nonnetwork providers	All covered expenses (except those for vision care and mail service prescription drugs) are subject to deductibles.
2. Deductible amounts	
a. Individual deductible	
1) *Network providers*	Each year a separate $250 deductible applies to each covered person. The deductible applies only once in any year even though the person may have several different accidental injuries or illnesses.
2) Nonnetwork providers	*Network* deductible provisions also apply to nonnetwork providers.
b. Family deductible	
1) *Network providers*	Each year, the plan limits the deductible amounts applied to the employee's family to $750. After the family deductible has been met, no further deductible is applied during that year to the employee or to the family members.

	Traditional Medical Plan
2) Nonnetwork providers	*Network* deductible provisions also apply to nonnetwork providers.

B. Copayments

	Traditional Medical Plan
1. Emergency room copayment	A $50 emergency room copayment applies to each *hospital* emergency room visit. The emergency room copayment does not apply if the patient: a) Is admitted to the *hospital* immediately following such treatment. b) Is treated in the emergency room for 12 or more hours. c) Dies in the emergency room. The emergency room copayment does not apply toward the individual deductible, family deductible, or out-of-pocket expense limits.
2. Office visit copayment	A $10 copayment applies to most covered office visits to a *network provider* (except for preventive care, inpatient *mental health*, and inpatient *substance abuse* services).
3. Mail Service Program prescription drug copayment	A $5 copayment applies to each covered generic prescription or refill obtained from the mail service pharmacy. A $15 copayment applies to each covered brand-name prescription or refill obtained from the mail service pharmacy. Covered prescription drugs obtained through the mail service program are not subject to the deductibles.

C. Plan Payment Levels

Plan payment levels are subject to all provisions of the Traditional Medical Plan, including medical review requirements, maximum benefits, coordination of benefits, exclusions, and definitions.

After satisfaction of the deductible and copayment requirements, the plan pays for covered medical services and supplies according to the following chart.

	Traditional Medical Plan
1. Network providers	Covered services of *network providers* are paid in full after any applicable copayments, except when provided for the treatment of *mental illness, substance abuse*, durable medical equipment, or TMJ/MPDS.

	Traditional Medical Plan
2. Nonnetwork providers	
a. *Physicians, hospitals*, and other covered health care providers in a license category eligible to participate in the *network*	
1) In service area	In a location where there are *network providers* qualified to provide *medically necessary services*, covered services are paid at 60 percent of *usual and customary* charges.*
2) Out-of-area	In a location where there are no *network providers* qualified to provide *medically necessary services*, covered services are paid at 100 percent of *usual and customary* charges.*
3) Emergency room	Covered services are paid according to *network* and nonnetwork provisions for medical emergencies.*
b. Other covered health care providers, services, and supplies furnished by providers not in a license category eligible to participate in the selected network	Covered services are paid at 80 percent of *usual and customary* charges.*
	*These payment levels do not apply to coverage of treatment for *mental illness, substance abuse,* durable medical equipment, or TMJ/MPDS.
3. Ambulance services	Covered ambulance services are paid at 100 percent of *usual and customary charges.*
4. Alternatives to hospitalization	Covered services and supplies provided by a *skilled nursing facility* or a *hospice agency* are paid at 100 percent of *usual and customary* charges.
5. Durable medical equipment, prostheses, and orthopedic appliances	Covered services and supplies are paid at 80 percent of *usual and customary* charges.
6. Treatment of *mental illness*	
a. Inpatient treatment coordinated through the network's *referral service*	Covered services for inpatient treatment of *mental illness* are paid in full.
b. Outpatient treatment coordinated through the network's *referral service*	Covered services for outpatient treatment of *mental illness* are paid in full after a $10 copayment per visit.
c. Treatment not coordinated through the network's *referral service*	Covered services for treatment of *mental illness* are paid at a constant 50 percent of *usual and customary* charges to a maximum of 20 inpatient days and 20 outpatient visits each benefit year if the services are certified as covered by the network's *referral service.*
7. Treatment of *substance abuse*	
a. Inpatient treatment coordinated through the network's *referral service*	Covered services for inpatient treatment of *substance abuse* are paid in full.
b. Outpatient treatment coordinated through the network's *referral service.*	Covered services for outpatient treatment of *substance abuse* are paid in full after a $10 copayment per visit.

	Traditional Medical Plan
c. Treatment not coordinated through the network's *referral service*	Covered services for inpatient and outpatient treatment of *substance abuse* are paid at a constant 50 percent of *usual and customary* charges.
d. Benefit maximum	Benefits are paid up to a lifetime maximum of two courses of treatment. Each course of treatment not coordinated by the *referral service* is subject to a $5,000 maximum.
8. Neurodevelopmental therapy	Covered services for neurodevelopmental therapy for children age six or younger are paid at network and nonnetwork levels to a maximum of $1,000 each benefit year.
9. Treatment of TMJ and MPDS	Covered services for treatment of TMJ and MPDS are paid at a constant 50 percent of *usual and customary* charges to a $3,500 lifetime maximum.
10. Preventive Care	
a. *Network providers*	Covered routine physical examinations for employees and spouses are paid in full up to $200 per examination, including related laboratory and X-ray charges.
b. Nonnetwork providers	No coverage for services obtained in a *network* service area.
11. Vision Care	Covered services are paid as specified in Section 11.F.
12. Prescription Drugs	
a. *Network*	
1) Generic	Covered generic prescription drugs are paid at 90 percent of charges when the preferred pharmacy identification card is used at a *participating pharmacy.*
2) Brand name	Covered brand-name prescription drugs are paid at 80 percent of charges when the preferred pharmacy identification card is used at a *participating pharmacy.*
b. Nonnetwork	Covered prescription drugs obtained without the use of the preferred pharmacy identification card are paid at 70 percent of the preferred pharmacy card program's contracted rates.
c. *Mail service prescription drug program*	Covered maintenance generic and brand-name prescription drugs obtained from the *network's mail service prescription drug program* are paid in full after the applicable copayment.
13. Out-of-Pocket Expense Limits	
a. *Network*	*Network* services are subject to the same limits described below for nonnetwork services.

	Traditional Medical Plan
b. Nonnetwork	When a covered person's out-of-pocket expenses reach $2,000 in any year, any further benefits that would have been paid at 60, 70, 80, or 90 percent will be paid at 100 percent of *usual and customary* charges (of contracted rates for prescription drugs) for the remainder of that year, to the maximum benefit amounts. When three or more family members satisfy their deductibles and have combined out-of-pocket expenses of $4,000 (but not more than $2,000 for any one individual), any further benefits that would have been paid at 60, 70, 80, or 90 percent will be paid at 100 percent of *usual and customary* charges (of contracted rates for prescription drugs) for the remainder of that year, to the maximum benefit amounts.
c. Expenses that do not count toward the individual or family out-of-pocket expense limits	1) Yearly deductibles. 2) Office visit copayments. 3) *Hospital* emergency room copayments. 4) Difference between *usual and customary* charges and the provider's actual charge. 5) Any balance remaining after a benefit maximum has been reached. 6) Covered medical services paid at 100 percent of *usual and customary* charges or in full. 7) Covered medical services for treatment of *mental illness, substance abuse,* or TMJ/MPDS. 8) Benefits paid at a reduced amount or denied when the patient fails to follow medical review program procedures and requirements.

D. Lifetime Maximum Benefit

The lifetime maximum benefit for all covered medical services (including prescription drugs) is $1,000,000, subject to all other medical plan provisions. This maximum applies separately to each covered family member. Benefits paid and applied to reduce the maximum benefit, while covered under a *Company-sponsored plan* for active or retired personnel and not reinstated under a prior agreement, are not reinstated by this agreement and serve to reduce the maximum benefits available hereunder.

Section 11. Traditional Medical Plan

Payment provisions are described in Section 10, except as noted under the vision care benefit.

A. Description

The Traditional Medical Plan provides benefits for procedures, services, and supplies *medically necessary* for the diagnosis and/or therapeutic treatment of nonoccupational accidental injuries or illnesses and treatment of certain listed conditions.

Enhanced benefits are available to employees who receive care from *network providers* as described in Section 10. Preventive care, prescription drug, and vision care benefits also are included in the plan.

B. Medical Review Program

The Traditional Medical Plan has a medical review program to encourage appropriate utilization of health care services. The program includes *precertification* requirements, voluntary second surgical opinion provisions, a *referral service* for *mental illness* and *substance abuse* treatment, and individual case management.

1. *Precertification* requirements.

   The employee is responsible for obtaining *precertification* for all nonemergency *hospital* admissions (except admissions for childbirth during the first 48 hours following a normal delivery or 96 hours following a cesarean section), *skilled nursing facility* admissions, and services for home health care and hospice care. Precertification of treatment of *mental illness* and *substance abuse* is handled separately through the Boeing mental health and substance abuse program.

   a. If the medical review program is not contacted, but retrospective review shows that the *hospital* or *skilled nursing facility* admission, home health care, or hospice care was *medically necessary*, regular plan benefits are reduced to 50 percent of *usual and customary* charges up to a maximum employee expense of $2,000.

      1) This $2,000 expense does not apply toward the yearly deductible and/or out-of-pocket expense limits.

      2) Benefits denied under other plan exclusions do not count toward this $2,000 expense.

   b. No benefits are provided for any services or supplies that are not *medically necessary*.

2. Individual case management.

   In the event of a severe or long-term illness or injury, the service representative will assist the patient's *network provider* in identifying treatment alternatives that offer cost-effective care and enhancements to the patient's quality of life.

3. *Referral service*.

   Employees and eligible dependents may use a *referral service* for treatment of *mental illness* and *substance abuse*. The *referral service* refers the patient to a *referral service provider* and precertifies initial treatment; ongoing treatment is precertified on a regular basis. Individuals who do not use the *referral service* receive reduced benefits.

4. Voluntary second surgical opinion provisions.

   The plan provides benefits for second surgical opinions the same as for other covered services provided by *network* and nonnetwork providers.

C. Preventive Care

1. Benefits are provided for a routine physical examination for employees and spouses as follows:

   a. One examination every three years for employees and spouses under age 35.

   b. One examination every year for employees and spouses age 35 and above.

2. Benefits are provided for the following routine screening examinations:

Mammograms, Pap smears, and prostate screenings (including the office visit) as recommended by the patient's *physician.*

3. The plan covers up to eight routine physical examinations for well-baby care during the child's first 24 months.
4. For children age two through age five, the plan covers one routine physical examination each year.
5. The plan covers routine childhood immunizations recommended by the child's *physician* according to American Academy of Pediatrics guidelines.

D. Covered Medical Services and Supplies

The Traditional Medical Plan provides benefits for the following *medically necessary services and supplies.* Benefits for special conditions are specified in Section 11.E.

1. The services of a *physician*, including:
   a. A voluntary second (or third) surgical opinion obtained from one or two other specialists.
   b. An eye examination including refraction performed in conjunction with a medical condition such as diabetes, glaucoma, and cataracts. (See Section 11.F for routine eye examination coverage.)
   c. Injectable legend drugs administered in a *physician's* office (including antigen, allergy serum, insulin, and contraceptive injections) for covered conditions; medical devices (including contraceptive devices and implants) dispensed by a *physician.* Preventive injections or immunizations are not covered except as described in Section 11.C.
2. Services of other health care professionals.
   a. Diagnostic X-ray and laboratory examinations, including examinations incurred in connection with a second (or third) surgical opinion.
   b. Intermittent visits of a registered nurse (R.N.), other than a nurse who ordinarily lives in the employee's home or who is a family member of the employee or spouse, if skilled care in place of hospitalization is not available through an alternative provider at a lesser cost.
   c. The services of a *physician's assistant* for services that would have been covered if performed by a *physician* licensed as a doctor of medicine (M.D.).
   d. The services of a *physical therapist* for physical therapy, the services of an *occupational therapist* for occupational therapy, and the services of a *speech therapist* for speech therapy, when specifically prescribed by a *physician* as to type and duration. Services must be performed under the *physician's* supervision while the patient remains under the attending *physician's* care, and only to the extent that the therapy will significantly restore bodily functions. The *physician* must reevaluate the therapy at least every three months and certify that continuing therapy is required. All therapy beyond three months must be approved by the service representative. Benefit determination is based on the attending *physician's* evaluation of the therapy as well as the therapist's progress reports. The information from the *physician* and therapist is then reviewed against established medical criteria to determine medical necessity.

      No benefits are payable for therapy given at the therapist's discretion, elected by the covered person, for any treatment for delayed development or therapy that solely is for the purpose of slowing body degeneration rather than restoring functional improvement, custodial maintenance, self-help, recreational therapy, or educational therapy.

Benefits also are provided for neurodevelopmental therapy for children age six and younger, up to a maximum benefit of $1,000 each benefit year.

e. The services of a *dentist* as specified in Section 11.E.6 and Section 11.E.10.

f. The services of an authorized Christian Science practitioner necessary for the healing treatment of a nonoccupational physical or mental condition.

g. Acupuncture services for a covered illness or in place of covered anesthesia when provided by a licensed acupuncturist (L.A.C.), or an M.D., or a doctor of osteopathy (D.O.).

3. Medical equipment, services, and supplies.

a. Professional ambulance service when used to transport the patient from the place of injury, accident, or illness to the first *hospital* where treatment is given. These services also are covered when the *physician* requires an ambulance to transport the patient to a *hospital* in the patient's area of residence to protect the patient's health or life. Air ambulance transportation is covered when *medically necessary.*

Ambulance service from one *hospital* to another, including return, is covered only if the facility is the nearest one with appropriate regional specialized treatment facilities, equipment, or staff *physicians.* Ambulance transportation from or to the patient's home is covered when *medically necessary.* No other expenses in connection with travel are covered.

b. The cost and installation of a hearing aid or aids purchased under a *physician's* or certified audiologist's written recommendation up to a $600 benefit payable for each hearing aid. This benefit is limited to one per ear every three consecutive years, including any period covered under a *Company-sponsored plan.* The plan also covers the overhaul of a hearing aid in place of a new hearing aid after three years.

No benefits are payable for:

1) Hearing or audiometric examinations. (When disease is present, such expenses may be covered under other portions of the Traditional Medical Plan.)

2) Hearing aids ordered either before the person became eligible or after coverage ends.

3) Hearing aids ordered before coverage ends but delivered more than 60 days after coverage ends.

4) Charges for hearing aids that do not meet professionally accepted standards of practice or for *experimental or investigational services or supplies.*

5) Replacement of hearing aids that are lost, broken, or stolen unless replacement is within the frequency limit of one hearing aid per ear every three consecutive years.

6) Replacement parts for hearing aid repairs, unless part of an overhaul after three years.

7) Replacement batteries.

8) Charges for eyeglass-type hearing aids above the covered expense for one hearing aid.

c. Hemodialysis in the patient's home when the treatment is repetitive and for chronic, irreversible kidney disease. Covered services and supplies include the rental, lease, or (under certain conditions) purchase of major hemodialysis equipment and specific supplies, and certain training necessary to operate the dialyzer. Purchase of specific supplies is contingent on the supplies having no real utility to the patient in the absence of the disease and having no value to other household members. Coverage

of the purchase of equipment is subject to specific conditions, including an amortization period, decided by the service representative.

d. Rental (or purchase if approved by the service representative) of durable medical or surgical equipment used exclusively for the patient's therapeutic treatment.

e. Orthopedic appliances and braces, including repair and replacement necessary as a result of normal usage or change in condition.

f. Oxygen and anesthesia.

g. Artificial limbs, artificial eyes, and other prostheses. This benefit includes repair and replacement necessary as a result of normal usage or change in condition.

h. Radiation therapy (including X-ray therapy) and chemotherapy.

4. *Hospital* room, board, services, and supplies, including a *medically necessary* private room. If a private room is used when one is not *medically necessary,* any excess of daily board and room charges over the *hospital's* average semiprivate room charge is not covered. If the *hospital* does not have semiprivate accommodations, the semiprivate charge for similar facilities in the area is considered in determining the rate.

   Hospital benefits are subject to the medical review program for medical necessity, appropriateness, level of care, and setting.

5. *Hospital* alternatives.

   a. Home health care visits and supplies provided to patients in their home by a *home health care agency* instead of confinement in a *hospital* or *skilled nursing facility.*

      Benefits are subject to the medical review program.

      1) To be eligible for benefits:

         a) Home health care visits and supplies must be for the *medically necessary* treatment of a covered illness or injury.

         b) A *physician* must establish a written *home health care treatment plan.*

         c) The patient must be homebound, which means leaving home involves a considerable, taxing effort and the patient is unable to use public transportation without assistance.

      2) Covered benefits for home health care visits and supplies must be provided by and billed by the *home health care* agency and are limited to:

         a) *Physician* services.

         b) Nursing visits by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).

         c) Physical therapy visits by a *physical therapist.*

         d) Speech therapy visits by a *speech therapist.*

         e) Occupational therapy visits by an *occupational therapist.*

         f) Medical social visits by a person with a master's degree in social work (M.S.W.).

         g) *Home health aide* visits.

         h) Respiratory therapy visits by an inhalation therapist certified by the National Board of Respiratory Therapists.

         i) Medical supplies dispensed by the *home health care agency* that would have been provided on an inpatient basis.

j) Nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.

k) Nutritional guidance by a registered dietician.

l) Services and supplies for infusion therapy. (Patients do not need to meet the treatment plan and homebound requirements.)

3) See Section 11.H for listed home health care exclusions.

b. Visits and supplies of a *hospice agency* when provided in place of confinement in a *hospital* or *skilled nursing facility*.

Benefits are subject to the medical review program.

1) To be eligible for benefits:

a) Hospice care visits and supplies must be for the *medically necessary* treatment or palliative care of terminally ill patients with a life expectancy of six months or less.

b) The *physician* must establish a written hospice care treatment plan.

2) Hospice visits and supplies in the patient's home must be provided by and billed by the *hospice agency* and are limited to the same items as listed under Section 11.D.5.a. In addition, benefits are provided for respite care for a minimum of two hours per day (continuous patient care to provide temporary relief to family members or friends).

3) Expenses for inpatient hospice confinement are covered to the same extent as if incurred in a *hospital*.

4) Limits.

a) Respite care of two or more hours per day when no skilled care is required is limited to a combined total of 120 hours in each three-month period.

b) Expenses for hospice care that qualify under this benefit and under any other benefit of this plan are covered only under the benefit the service representative determines as the most appropriate.

5) See Section 11.H for listed hospice care exclusions.

c. *Skilled nursing facility* room, board, services, and supplies when provided in place of *medically necessary* hospitalization, limited to the facility's average semiprivate room charge. If the *skilled nursing facility* does not have semiprivate accommodations, the semiprivate charge for similar facilities in the area is considered in determining the rate.

Benefits are subject to the medical review program for medical necessity, appropriateness, level of care, and setting.

d. Expenses incurred for room and board while in a *Christian Science sanatorium* also are covered if the patient is admitted for healing (not rest or study) and is under the care of an authorized Christian Science practitioner. If a private room is used, any excess of daily room and board charges over the facility's average semiprivate room charge is not covered. If the facility does not have semiprivate accomodations, the semiprivate charge for other *Christian Science sanatoriums* will be considered in determining the rate.

e. Services of an approved freestanding surgical center or hospital-based emergency facility if such services would be covered if received in a *hospital*.

E. Special Conditions

Covered medical services and supplies described in Section 11.D also are provided for the following special conditions.

1. Congenital abnormalities and hereditary complications.

   Benefits are provided for *medically necessary services and supplies* required for the treatment of congenital abnormalities and hereditary complications. This coverage applies to newborn children as well as to all other persons covered under the plan.

2. Cosmetic surgery.

   Benefits are provided for cosmetic surgery only if the surgery is for prompt repair of an accidental injury.

3. Erectile dysfunction.

   Benefits are provided for the treatment of organic erectile dysfunction when the patient has a history of one or more of the following:

   a. Peripheral vascular disease or local penile vascular abnormalities.

   b. Peripheral neuropathy or autonomic insufficiency.

   c. Prostate cancer.

   d. Spinal cord disease or injury.

   e. Major pelvic surgery.

   f. Insulin-dependent diabetes appearing before age 50.

   g. Severe Peyronie's disease.

   Covered therapy includes vacuum erection device, injection therapy, penile prosthesis, urethral pellets, and prescription medications.

   The plan does not cover treatment for nonorganic impotence such as psychosexual dysfunction.

4. Infertility.

   Benefits are provided for the following services in connection with the diagnosis and treatment of infertility:

   a. Diagnostic tests necessary to determine the cause of infertility.

   b. Surgical correction of a condition causing or contributing to infertility.

   c. Conventional medical treatments (such as office visits, laboratory services, and prescription medications) of the infertility.

   The plan does not cover the infertility services and supplies listed in Section 11.H.

5. *Mental illness* and *substance abuse* treatment.

   a. *Mental illness* (including eating disorders).

      Benefits are provided for the services of the following providers in connection with the inpatient and outpatient treatment of *mental illness:*

      1) Any provider contracted with the *referral service.*

      2) Licensed psychiatric doctor (M.D.).

      3) Licensed clinical psychologist.

      4) Licensed psychiatric nurse (R.N.).

5) Professional at master's level or above who is licensed in the area where the services are performed.

6) Licensed *hospital* or treatment facility.

Treatment of a *mental illness* includes only treatment of a mental disorder or condition not related to, accompanying, or resulting from *substance abuse*. Treatment of any such related, accompanying, or resulting disorder or condition is considered to be treatment of the *substance abuse*.

b. *Substance abuse*.

Expenses incurred at a *substance abuse treatment facility* or a *hospital*, including *physician's* charges and charges for prescription drugs, are covered only to the extent they are in connection with the effective treatment of *substance abuse*. The benefit at a *substance abuse treatment facility* is limited to intensive inpatient treatment and outpatient *substance abuse* counseling as prescribed by a *physician*.

No benefits are provided for: recovery houses that provide an alcohol- or drug-free residential setting; alcohol or drug information and referral services; schools; emergency service patrols; or detoxification, except when immediately followed by a rehabilitative program.

The patient must complete the course of treatment to be eligible for *substance abuse* benefits.

6. Oral surgery.

a. Benefits are provided only to the extent not covered under the Network Dental Plan for services in connection with the prompt repair of natural teeth or other body tissue performed by a *physician* or a *dentist* and required as a result of a nonoccupational injury, provided that:

1) The damaged, lost, or moved teeth were free from decay or in good repair and firmly attached to the jaw bone at the time of the injury.

2) If crowns (caps), dentures (false teeth), bridgework (fixed or removable), or in-mouth appliances are installed due to such injury, only charges for the first denture or bridgework to replace lost teeth, the first crown needed to repair each damaged tooth, and an in-mouth appliance used in the first course of orthodontic therapy after the injury are included.

Charges to remove, repair, replace, restore, or reposition teeth lost or damaged while biting or chewing are not covered.

b. Benefits are provided for *medically necessary* services in connection with oral surgery performed by a *physician* or *dentist* for a medical condition that does not relate to the correction of the gum, teeth, or mouth tissues for dental purposes, except where covered under the Network Dental Plan. These services include, but are not restricted to:

1) Removal of tumors and cysts of the jaw, cheeks, lips, tongue, and roof and floor of the mouth.

2) Surgical procedures required to correct accidental injuries of the jaw, cheeks, lips, tongue, and roof and floor of the mouth.

3) Removal of exostoses of the jaw and hard palate.

4) Treatment for fractures of the facial bones (maxilla or mandible).

5) Incision and drainage of cellulitis.

6) Incision of accessory sinuses, salivary glands, or ducts.

c. Benefits are provided for *physician* or *dentist* services in connection with the correction of developmental abnormalities of the jaw or malocclusion of the jaw by osteotomy (the surgical cutting of bone or bony tissue) with or without bone grafting.

d. The surgical placement of endosseous implants is covered if there is a reasonable expectation of success for a minimum of five years.

e. *Hospital* services and benefits for general anesthesia are provided in connection with other dental or oral surgery when *medically necessary.*

The preceding listed services incurred in connection with dental work or oral surgery do not apply to any services in connection with the diagnosis and treatment of temporomandibular joint disease (TMJ) or myofascial pain dysfunction syndrome (MPDS). See Section 11.E.10.

7. Pregnancy.

Benefits are provided for pregnancy the same as any other condition for covered employees or covered dependents, provided that expenses are incurred while this coverage is in force.

Pregnancy includes normal delivery, cesarean section, spontaneous abortion (miscarriage), legal abortion, and complications of pregnancy.

Following childbirth, mothers and newborns may stay in the *hospital* for 48 hours following a normal delivery or for 96 hours following a cesarean section, unless a shorter stay is authorized by the attending health care provider in consultation with the mother. Preadmission review is not required for these lengths of stay. Any length of stay beyond 48 hours or 96 hours must be approved through the medical review program.

Benefits are provided for a *birthing center* only to the extent that such services would have been covered in a *hospital.*

A newborn child is eligible from the date of birth if the child qualifies as a dependent of the employee and is enrolled within 120 days. The following services and supplies are covered for a newborn child enrolled in the plan, subject to the plan payment provisions listed in Section 10:

a. Routine *hospital* services and supplies and *physician* services during the first 48 hours following a normal delivery or 96 hours following a cesarean section.

b. *Medically necessary hospital* and *physician* services and supplies.

8. Reconstructive breast surgery.

Covered individuals receiving benefits for a mastectomy may elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the patient and attending *physician.* Covered services include the following:

a. All stages of reconstruction of the breast on which the mastectomy was performed.

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

c. Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These reconstructive benefits are subject to the plan payment provisions listed in Section 10, as are other medical and surgical benefits covered under the medical plans.

9. Sterilization (vasectomy and tubal ligation).

Benefits are provided for a vasectomy or tubal ligation, but not a reversal.

10. Temporomandibular joint disease (TMJ) and myofascial pain dysfunction syndrome (MPDS).

    a. The following surgical or nonsurgical treatment of TMJ or MPDS by a *physician* or a *dentist* are included as covered medical services and supplies:

        1) Initial diagnostic examinations and X-rays.

        2) Follow-up office visits.

        3) Surgical procedures and related hospitalization.

        4) Appliances (i.e., nightguards, bite plates, orthopedic repositioning, or mandibular orthopedic devices).

        5) Appliance management, kinesitherapy, physical therapy, biofeedback therapy, joint manipulation, prescription drugs, injections of muscle relaxants, and therapeutic drugs or agents.

    b. The following expenses are not covered:

        1) Restorative techniques to build occlusion unless the tooth is diseased or accidentally damaged.

        2) Nonsurgical orthodontic treatment, except as provided above.

        3) Banding treatment.

11. Transplant benefits.

    Benefits are provided for *medically necessary* services relating to a covered transplant. Transplants that are part of an approved clinical trial also may be covered.

    a. If the patient covered by this plan is the recipient of a human organ or tissue transplant covered by this plan, donor organ procurement costs are covered to a maximum benefit of $30,000 per transplant, to a lifetime maximum benefit of $60,000. Benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other *medically necessary* procurement costs. Donor expenses that are covered under this plan are applied against the plan lifetime maximum benefit for the recipient covered under this plan.

    b. No benefits are provided for the following:

        1) Nonhuman, artificial, or mechanical transplants.

        2) *Experimental or investigational services or supplies* unless they are part of an approved clinical trial.

        3) Services and supplies for the donor when donor benefits are available through other group coverage.

        4) Expenses for that portion of treatment funded by government or private entities as part of an approved clinical trial.

        5) Expenses when the recipient is not covered under this plan.

        6) Lodging, food, or transportation costs, unless otherwise specifically provided under this plan.

        7) Donor and procurement services and costs incurred outside the United States, unless specifically approved by the service representative.

        8) Living (noncadaver) donor transplants (except kidney, liver, lobar lung, and bone-marrow or stem cell transplants for covered conditions) including selective islet cell transplants of the pancreas.

F. Vision Care Benefit

Vision care benefits are subject to all Traditional Medical Plan provisions except the annual deductible and plan payment levels. Vision care benefits are included in the Traditional Medical Plan maximum lifetime benefit.

1. Covered vision care expenses are the *usual and customary* charges (up to the amounts shown in the schedule) for the following:
   a. A complete eye examination, which must include refraction, performed by a legally qualified ophthalmologist or optometrist.
   b. Prescribed lenses.
   c. Contact lenses if elected in lieu of conventional lenses and frames.
   d. Frames required for prescription lenses.

   Benefits are provided for one eye examination every year and two sets of lenses and two frames every two years. This period includes the time covered under a *Company-sponsored plan.* The plan covers contact lenses when purchased in place of lenses and frames, or when purchased in combination with lenses and frames, up to a combined maximum benefit of $210. Any replacement of lost, stolen, or broken lenses and/or frames is included under the two-set limit.

Schedule of Covered Vision Care Expenses

Services and Supplies	Maximum Covered Expense ($)
Eye Examination	Paid in full after $10 office visit copayment for network provider services; 60 percent up to $50 for nonnetwork provider services.
Lenses:	
Single vision (2 lenses)	50
Bifocal (2 lenses)	80
Trifocal (2 lenses)	95
Lenticular (2 lenses)	155
Frames	70
Contact Lenses (2 lenses), in place of allowances for conventional lenses and frames above	105

All other vision care expenses are not covered under this benefit, but may be covered as a medical condition.

2. The following vision care expenses are not covered:
   a. Special supplies, such as nonprescription sunglasses and subnormal vision aids.
   b. Special lens treatment such as seamless lenses (e.g., Varilux and Ultravue) over the amount covered for lenses without this feature.
   c. Antireflective coatings, tinting, charges for sunglasses, or light-sensitive glasses over the amount covered for nontinted glasses.
   d. Services or supplies not listed as covered expenses.

e. Services or supplies received while the individual was not a covered family member or charges for lenses and frames furnished or ordered before the individual became a covered family member.

Expenses incurred for lenses and frames within 31 days after coverage ends are covered, but only if a complete eye examination, including refraction, was performed during the 31-day period immediately before coverage ends and resulted in a prescription of eyeglasses for the first time or a change in prescription.

G. Prescription Drug Benefit

Benefits are subject to all Traditional Medical Plan provisions, including exclusions.

1. Preferred pharmacy card program.

a. Description of benefit.

Employees and dependents may obtain covered prescription drugs through the preferred pharmacy card program or through any licensed pharmacist.

b. Covered prescription drug expenses.

The plan covers the following *medically necessary* prescription drug expenses:

1) Legend drugs (including contraceptive medications), which must be dispensed under federal or state law through the written prescription of a *physician* or *dentist.*

2) Injectable insulin (including needles, syringes, chem strips, chem pads, and lancets when prescribed along with insulin) when ordered in writing by the patient's *physician.*

3) Antigen or allergy serum prescribed by a *physician* in writing.

c. Maximum medication covered.

The program covers a supply of medication which, when taken according to the *physician's* written order, does not exceed a 30-day supply. Certain drugs are subject to other quantity limits.

2. *Mail service prescription drug program.*

a. Description of benefit.

Employees and eligible dependents may use the *mail service prescription drug program* to obtain covered maintenance prescription drugs. Maintenance prescription drugs are prescription drugs taken on an ongoing basis to control chronic medical conditions.

Unless your *physician* indicates otherwise, a generic equivalent of the prescribed drug will be dispensed when available and permissible under the law.

b. Covered prescription drug expenses.

The plan covers the following *medically necessary* prescription drug expenses:

1) Legend drugs (including contraceptive medications), which must be dispensed under federal or state law through the written prescription of a *physician* or *dentist.*

2) Injectable insulin (including needles, syringes, chem strips, chem pads, and lancets when prescribed along with insulin) when ordered in writing by the patient's *physician.*

c. Maximum medication covered.

The program covers a supply of medication which, when taken according to the *physician's* written order, does not exceed a 90-day supply per prescription or refill. Authorized refills are covered only after the initial substance has been used. Certain drugs are subject to other quantity limitations.

3. Exclusions.

No benefits are payable under the prescription drug programs for the following:

a. Appliances, devices, or other nondrug items, including but not limited to therapeutic devices or artificial appliances. However, this does not apply to needles, syringes, or other diabetic supplies, when prescribed along with insulin.

b. Any charges for the administration or injection of any drug.

c. Any prescription for which the person is eligible to receive benefits under another employer's group benefit plan or a workers' compensation law or from any municipality, state, or federal program.

d. Any prescription filled in excess of the number prescribed by the *physician* or any refill after one year from the date of the *physician's* order.

e. Immunizing agents, except that allergy serum (antigen) is covered under the prescription drug card program with a *physician's* written prescription.

f. All medications to treat sexual dysfunction, unless the patient is being treated for a diagnosed medical condition.

g. Fertility agents, unless approved by the service representative.

h. Obesity drugs.

i. Drugs dispensed during an inpatient admission by a *hospital, skilled nursing facility,* sanatorium, or other facility.

j. Experimental drugs or drugs used for investigational purposes.

k. Drugs that are not *medically necessary* for the treatment of an illness, injury, or other covered condition, including vitamins, except as specifically provided by the plan.

l. Infusion therapy drugs except as described in the home health care benefit.

m. Delivery or handling charges.

n. Any service or supply otherwise excluded by the plan.

H. Traditional Medical Plan Exclusions

These charges are deducted from the eligible person's expenses before the benefits of this plan are determined. The plan does not pay for charges for or related to:

1. Any accident or illness covered by a workers' compensation law.

2. Services or supplies not recommended and approved by a *physician* or other covered health care professional or provided before the person becomes covered under this plan.

3. Services and supplies that the plan's service representative determines are not *medically necessary* for treatment of an accidental injury, illness, or other condition covered under the plan. This includes routine physical examinations, immunizations, and other preventive services and supplies, except as specifically provided by the plan.

Inpatient *hospital* care (including *physician* visits while hospitalized) is not considered *medically necessary* when the care can be provided safely in an outpatient setting, such

as a *hospital* outpatient department, *physician's* office or an ambulatory surgical facility, without adversely affecting the patient's physical condition.

Examples of care that generally should be provided in an outpatient setting include observation and/or diagnostic studies, surgery that can be performed on a same-day basis, and psychiatric care primarily aimed at controlling or changing the patient's environment.

4. Amounts exceeding *usual and customary* charges.
5. *Skilled nursing facility* services when the services usually are not provided by such facilities or when the services are not expected to lessen the disability and enable the person to live outside the facility. However, *skilled nursing facility* services are covered for the terminal patient when the illness has reached a point of predictable end.
6. Services or supplies related to cosmetic surgery, except as specifically provided by the plan.
7. Services or supplies related to obesity, unless approved in advance by the service representative according to written guidelines. Employees may request a copy of the guidelines by calling the service representative.
8. Any treatment or services required in connection with a sex transformation.
9. Services or supplies to the extent they are covered under any *Company-sponsored plan* that has been discontinued.
10. Services or supplies to the extent they are covered under any federal, state, or other government plan, except where required by law.
11. Confinement, surgical, medical, or other treatment, services, or supplies received in or from a U.S. Government *hospital*, except as required by law.
12. Services or supplies for which no charge is made or charges the employee or dependent is not required to pay.
13. Dyslexia, visual analysis therapy, or training related to muscular imbalance of the eye or for orthoptics. However, coverage is provided for up to six months when necessary to correct muscle imbalance (strabismus, esotropia, or exotropia) if treatment begins before the person's 12th birthday.
14. Completion of claim forms or reports.
15. Full body computerized axial tomography (CAT) scans other than at a *hospital* or an institution having an agreement with a *hospital* to supply these services. However, expenses are covered under other circumstances if the equipment is required and certified by the *physician* for immediate use to diagnose a potentially life-threatening condition or if the services are provided at a *physician's* office, clinic, or other institution approved by the Company for other than emergency use.
16. Benefits payable under any automobile medical, personal injury protection (PIP), automobile no-fault, automobile uninsured or underinsured motorist, homeowner's, or commercial premises medical coverage, when such contract or insurance is issued to or provides benefits available to the patient. Any benefits paid by this plan before benefits are paid under one of these other types of contracts or insurance are provided to assist the patient and do not indicate the service representative is acting as a volunteer or waiving any right to reimbursement or subrogation.
17. *Experimental or investigational services or supplies*, or related complications.
18. Services or supplies related to treatment of *mental illness*, including eating disorders, or *substance abuse*, except as specifically provided by the plan.

19. Services or supplies related to treatment of TMJ and MPDS, except as specifically provided by the plan.
20. Radial keratotomy or other eye surgery to correct refractive errors, except when preoperative visual acuity is 20/50 or less with a lens.
21. Reversal of a sterilization procedure.
22. Infertility services or supplies, including but not limited to in vitro fertilization; artificial insemination; embryo transfer; gamete intrafallopian transfer (GIFT); microinjections; zona drilling; sperm preparation; sperm separation; fertility drugs (including but not limited to Clomid, Pergonal, Serophene, or HCG) when associated with any artificial means of conception; consecutive follicular ultrasounds, cycle therapy, or corresponding lab tests when associated with any artificial means of conception; any tests, visits, consultations, or treatment related to, or resulting in, one of the preceding listed noncovered services.
23. *Custodial care.*
24. Services or supplies required by law to be provided by any school system.
25. Education, special education, or job training, whether or not provided by a facility that also provides medical or psychiatric care.
26. Marriage counseling, family counseling, child counseling, career counseling, social adjustment counseling, pastoral counseling, or financial counseling.
27. Intentionally self-inflicted injury, unless under treatment for a *mental illness.*
28. Missed appointments.
29. Equipment or supplies that are not solely related to the medical care of a diagnosed illness or injury. Examples include, but are not limited to, any luxury or convenience item or supply, general exercise equipment, modification to home (e.g., wheelchair ramps, support railings) or automobile or van (e.g., ramps, lifts), environmental control devices (e.g., air conditioners, purifiers, humidifiers), swimming pool, spa or whirlpool, Craftmatic or similar bed, orthopedic chair, special car seat, or any personal hygiene item.
30. The following home health care and hospice services:
    a. Homemaker or housekeeping services.
    b. Services provided by volunteers, household members, family, or friends.
    c. Unnecessary or inappropriate services, food, clothing, housing, or transportation.
    d. Social services.
    e. Psychiatric care.
    f. Maintenance or *custodial care.*
    g. Supplies or services not included in the written *home health or hospice care treatment plan* or not otherwise covered.
    h. Hospice services to other family members, including bereavement counseling.
    i. Hospice services of financial, legal, or spiritual counselors.

I. Right to Receive and Release Necessary Information

As a condition of receiving benefits under this plan, the patient agrees to authorize:

1. Any *physician, hospital,* or other provider or party having knowledge to disclose to the service representative any medical information requested to administer this plan.
2. The service representative to

a. Examine medical records at the offices of any *physician, hospital,* or other provider to verify services or supplies.

b. Release to or obtain from any other insurer, organization, or person any information necessary to administer the coordination of benefits provisions.

c. Exercise the subrogation rights described in Section 14 releasing any information about the accident, injuries, and benefits or services received to any person who may be liable to the patient, to that person's insurer, or to the service representative.

d. Examine employment and payroll records of the patient to verify plan eligibility and enrollment.

3. The service representative will keep this information confidential whenever possible, but under certain circumstances it may be disclosed to other parties, such as:

a. To a law enforcement or other governmental authority in case of fraud or illegal activity.

b. In response to a subpoena or judicial order.

c. To a medical person or institution to verify coverage or to conduct an audit.

d. To a professional review organization to review the service or conduct of a medical person or institution.

4. The patient waives any claim of privilege or confidentiality in any action by or against the service representative or the party furnishing the information.

Section 12. Network Dental Plan

A. Description

Under the Network Dental Plan, employees and eligible dependents may receive dental care from any licensed *dentist.* However, benefits are paid at a higher level if the services are received from a *network provider. Network providers* have agreed to bill the plan's service representative directly, eliminating the need for claim forms.

B. Deductibles

Deductibles are expenses for certain covered services and supplies that the employee or dependent must pay each benefit year before benefits are payable. The deductible amount depends on whether dental treatment is received from *network* or nonnetwork providers. *Network* and nonnetwork deductibles are combined when services and supplies are received from both *network* and nonnetwork providers during a benefit year.

1. *Network* Deductible

The annual deductible for services received from *network providers* is $50 per individual. For families of three or more, the *network* deductible for all family members will not exceed $150 in a benefit year. The *network* deductible applies to all services and supplies received from *network providers* except diagnostic, preventive, and orthodontic services and supplies.

2. Nonnetwork Deductible

The annual deductible for services received from nonnetwork providers is $75 per individual. For families of three or more, the nonnetwork deductible for all family members will not exceed $225 in a benefit year. The nonnetwork deductible applies to all services and supplies received from nonnetwork providers except orthodontic services and supplies.

C. Plan Payment Levels

The plan pays for covered services and supplies as follows:

1. Services and supplies received from *network providers.*
   a. Class I diagnostic and preventive services and supplies are paid at 100 percent of *recognized fees.*
   b. Class II oral surgery, minor restorative, periodontic, and endodontic services and supplies are paid at 80 percent of *recognized fees.*
   c. Class III major restorative and prosthodontic services and supplies are paid at 60 percent of *recognized fees.*
   d. Class IV orthodontic services and supplies are paid at 50 percent of *recognized fees.*
2. Services and supplies received within the *network* service areas from other covered *dentists* who are not *network providers.*
   a. Class I diagnostic and preventive services and supplies are paid at 80 percent of *recognized fees.*
   b. Class II oral surgery, minor restorative, periodontic, and endodontic services and supplies are paid at 50 percent of *recognized fees.*
   c. Class III major restorative and prosthodontic services and supplies are paid at 50 percent of *recognized fees.*
   d. Class IV orthodontic services and supplies are paid at 50 percent of *recognized fees.*
3. Services and supplies received outside the *network* service areas are paid at *network* payment levels.

D. Maximum Benefits

Except for orthodontic treatment, the maximum benefit payable for all dental services is $2,000 for each eligible person each year.

For orthodontic treatment, the lifetime maximum benefit is $2,000 during all periods the eligible person is covered under any *Company-sponsored plan.*

E. Covered Services and Supplies

The following services and supplies are covered under the Network Dental Plan. Coverage is subject to the benefit payment levels, maximums, exclusions, and other provisions of the plan.

1. Diagnostic (Class I) services and supplies.

   The plan covers the following diagnostic services and supplies:

   a. Routine examinations, twice in a benefit year.
   b. Complete series (four bitewing X-rays and up to 10 periapical X-rays) or Panorex X-rays, once in a three-year period.
   c. Supplementary bitewing X-rays, twice in a benefit year.
   d. Emergency examinations.
   e. Biopsy/tissue examination (also called a histopathic examination). The surgery part of the biopsy is covered as a Class II oral surgery procedure.
   f. Examinations by a specialist for consultation are covered up to three times in a six-month period if the *dentist* is in a specialty field recognized by the American Dental Association and if the patient is not receiving treatment from the specialist.

The plan does not cover diagnostic services and X-rays related to temporomandibular (jaw) joints, consultations, elective second options, study models, or caries (decay) susceptibility tests.

2. Preventive (Class I) services and supplies.

   The plan covers the following preventive services and supplies:

   a. Prophylaxis (cleaning), once in a four-month period.

   b. Topical application of fluoride (or preventive therapies such as fluoridated varnishes), twice in a benefit year for dependent children through age 18.

   c. Fissure sealants for dependent children through age 14. If eruption of a permanent molar is delayed beyond age 14, sealants will be allowed, with documentation from the attending *dentist*, if applied within 12 months of eruption. Fissure sealants are topically applied acrylic, plastic, or composite material used to seal developmental grooves and pits in the child's teeth to prevent dental decay. The plan covers only sealants applied to permanent molar teeth that have intact occlusal surfaces, no decay, and no prior restorations. The repair or replacement of a sealant on any tooth within three years of its initial placement is considered part of the original service.

   The plan does not cover home fluoride kits, cleaning of *prosthetic appliances*, replacement of space maintainers previously paid for by the plan, plaque control programs, oral hygiene instruction, or dietary instruction.

3. Restorative (Class II and III) services and supplies.

   To determine the appropriate benefit payment level for covered restorative services and supplies, restorations using filling materials are considered Class II services and supplies, while restorations using crowns, inlays, or onlays are considered Class III services and supplies.

   The plan covers the following restorative services and supplies:

   a. Amalgam, composite, or filled resin restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp).

   b. Stainless steel crowns. (See below.)

   c. Composite or filled resin restorations placed in the front surface of bicuspids.

   Restorations on the same surface or surfaces of a tooth are covered once in a two-year period. Crowns, inlays, and onlays (whether gold, porcelain, plastic, gold substitute casting, or a combination of these materials) are covered on the same tooth once in a five-year period. Stainless steel crowns are covered once in a five-year period (once in a two-year period for primary teeth).

   If a composite or plastic restoration is placed on a posterior tooth, the plan covers up to the amount allowed for an amalgam restoration. If a tooth can be adequately restored with a filling material but a crown, inlay, or onlay is elected instead, the plan covers the restoration as if a filling material had been used.

   The plan covers the use of a crown as an abutment to a partial denture only when the tooth is decayed to the extent that a crown would be required whether or not a partial denture is required.

   The plan does not cover restorations necessary to correct vertical dimension or to alter morphology (shape) or occlusion, overhang removal, or recontouring or polishing a restoration.

4. Oral surgery (Class II) services and supplies.

The plan covers the following surgical procedures:

a. Surgical and nonsurgical extractions.

b. Preparation of the alveolar ridge and soft tissues of the mouth for the insertion of dentures.

c. Treatment of pathological conditions and traumatic facial injuries.

d. General anesthesia or intravenous sedation, only when administered by a licensed *dentist* in connection with a covered oral surgery procedure.

The plan does not cover iliac crest or rib grafts to alveolar ridges, ridge extensions for insertion of dentures (vestibuloplasty), or tooth transplants.

5. Periodontic (Class II) services and supplies.

The plan covers services and supplies for the following surgical and nonsurgical procedures when used to treat tissues that support the teeth:

a. Periodontal scaling or root planing, once in a 24-month period.

b. Site-specific therapies for patients with pockets of at least 5 mm but not more than 10 mm. The plan covers Actisite procedures for two sites per quadrant once every 18 months and application of PerioChip for initial placement.

c. Gingivectomy.

d. General anesthesia or intravenous sedation, covered only when administered by a licensed *dentist* in connection with a covered oral surgery procedure.

e. Limited adjustments to occlusion (eight or fewer teeth), such as the smoothing of teeth or reduction of cusps.

The plan does not cover periodontal splinting or any crown or bridgework provided with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances, gingival curettage, or major (complete) occlusal adjustment.

6. Endodontic (Class II and III) services and supplies.

To determine the appropriate benefit payment level, covered endodontic services and supplies generally are considered Class II services and supplies. However, if root canal treatment is provided in conjunction with an overdenture, the plan pays benefits for such treatment as part of Class III services and supplies.

The plan covers pulpal and root canal treatment on the same tooth (including pulpotomy and apicoectomy) once in a two-year period. General anesthesia or intravenous sedation is covered only when administered by a licensed *dentist* in connection with a covered oral surgery procedure. Tooth bleaching, whether vital or nonvital, is not covered.

7. Prosthodontic (Class III) services and supplies.

The plan covers the following:

a. Full or immediate dentures. If any other procedure is provided (such as personalized restorations or specialized treatment), the plan applies the appropriate amount for a full or immediate denture toward the cost.

b. Cast chrome or acrylic partial dentures. If a more elaborate or precise device is used, the plan applies the appropriate amount for covered partial dentures toward the cost.

c. Stayplate dentures for replacing anterior teeth during the healing period, or in children age 16 or younger for missing anterior permanent teeth.

d. Fixed bridges.

e. Inlays (only when used as an abutment for a fixed bridge), once in a five-year period.

f. Removable partial dentures.

g. The adjustment or repair of an existing prosthetic device. Replacement of an existing prosthetic device is covered once in a five-year period, and only if it is not serviceable and cannot be made serviceable.

The plan also limits the frequency that certain prosthodontic services and supplies are covered, as follows:

h. Replacement of an existing prosthetic device once in a five-year period and only then if it is unserviceable and cannot be made serviceable. Expenses related to making the device serviceable are covered.

i. Denture adjustments and relines if these services are provided more than six months after the initial placement occurs. Denture adjustments are covered twice in a 12-month period. Later relines and jump rebases (but not both) are covered once in a 12-month period.

The plan does not cover duplicate dentures, personalized dentures, cleaning of *prosthetic appliances*, temporary dentures, porcelain or resin inlay bridges, surgical placement or removal of implants or attachments to implants, or crowns and copings provided in conjunction with overdentures. The plan also does not cover fixed prosthodontics for children under age 16.

8. Orthodontia (Class IV) services and supplies.

To determine the appropriate benefit payment level, covered orthodontia services and supplies are considered Class IV services and supplies. The plan covers orthodontia treatment (including the correction or prevention of malocclusion) for employees and eligible dependents.

The plan covers nightguards and occlusal splints as orthodontia treatment expenses.

F. Exclusions

The Network Dental Plan will not pay for charges for or related to:

1. Services for injuries or conditions that are compensable under workers' compensation or employers' liability laws or services provided by any federal, state, or provincial government agency or provided without cost by any municipality, county, or other political subdivision.
2. Services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
3. Dentistry for cosmetic reasons.
4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion, or erosion, or restorations for malalignment of teeth.
5. Implants.
6. Application of desensitizing agents.
7. *Experimental services or supplies.*
8. General anesthesia or intravenous sedation, except as specified for oral, periodontal, or endodontic surgical procedures.
9. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, injections, or prescription drugs.

10. Treatment provided when you fail to obtain a required examination from a plan-appointed consultant *dentist* for review of a request for benefits.
11. Hospitalization charges or any additional fees charged by the *dentist* for *hospital* treatment.
12. Fees for broken appointments.
13. Patient management problems.
14. Fees for completing insurance forms.
15. Habit-breaking appliances.
16. Services specifically excluded in this dental coverage description.
17. All other services not specifically included in this plan as covered dental benefits.

G. Extended Dental Benefits Following Termination of Coverage

The plan generally does not cover services an employee or eligible dependent receives while not covered under the plan. However, the plan covers crowns, bridges, dentures, and root canals during the 31 days following termination of the eligible person's coverage if the *dentist* has started the course of treatment before the eligible person's coverage ends.

Services in connection with a prosthetic device, including the abutment crowns of a partial denture, are covered if the denture impressions were taken while the eligible person was covered under the plan. However, the prosthetic device must be installed or delivered to the eligible person within the 31 days following termination of coverage. Services are not covered if the denture impressions were taken before the date coverage became effective. If the impressions were taken after coverage terminated, the services must meet the requirements described in the preceding paragraph.

Services in connection with a crown required for the restoration of a tooth (independent of the use of the crown in connection with a partial denture) are covered if the tooth was prepared for the crown before coverage terminated and the crown is seated during the 31 days following termination of the eligible person's coverage. Otherwise, the crown must be installed according to the requirements described above.

The plan covers services and supplies in connection with covered orthodontia care if such services and supplies are provided during the three calendar months following termination of the eligible person's coverage.

See Section 16 for other coverage continuation options following the termination of your coverage.

Section 13. Coordination of Benefits

If an employee or dependent has medical, dental, or other health coverage in addition to being covered under these medical and dental plans, the following rules govern coordination of benefits with the other coverage. Other coverage includes, whether insured or uninsured, another employer's group benefit plan, other arrangement of individuals in a group, Medicare (to the extent allowed by law), individual insurance or health coverage, and insurance that pays without consideration of fault.

The service representative has the right to obtain and release any information or recover any payment it considers necessary to administer these provisions.

The exclusion of government benefits and services is described in "Traditional Medical Plan Exclusions" in Section 11.H and in "Exclusions" for the Network Dental Plan in Section 12.F.

A. Order of Payment

The primary plan pays its benefits first and pays its benefits without regard to benefits that may be payable under other plans. When another plan is the primary plan for health care coverage, the secondary plan pays the difference between the benefits paid by the primary plan and what would have been paid had the secondary plan been primary.

1. A plan is considered primary if:
   a. It has no order of benefit determination rules.
   b. It has benefit determination rules that differ from coordination of benefit rules under state regulations or, if not insured, that differ from these rules.
   c. All plans that cover an individual use the same coordination of benefit rules, and under those rules, the plan is primary.
2. If the aforementioned rules do not determine which group plan is considered primary, this plan applies the following coordination of benefit rules:
   a. A plan that covers a person as an employee, retiree, member, or subscriber pays before a plan that covers the person as a dependent.
   b. A plan that covers a person as an active employee or dependent of an active employee is primary. The plan that covers a person as a retired, laid-off, or other inactive employee or as a dependent of a retired, laid-off, or other inactive employee is secondary.
   c. If a dependent child is covered under both parents' group plans, the child's primary coverage is provided through the plan of the parent whose birthday comes first in the calendar year, with secondary coverage provided through the plan of the parent whose birthday comes later in the calendar year.
   d. If a dependent child's parents are divorced or separated and a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility is the primary plan of coverage. If the divorce decree is silent on the issue of coverage, the following guidelines are used:
      1) The plan of the parent with custody pays benefits first.
      2) The plan of the spouse of the parent with custody pays second.
      3) The plan of the parent without custody pays third.
      4) The plan of the spouse of the parent without custody pays fourth.
   e. If none of the aforementioned rules establishes which group plan should pay first, then the plan that has covered the person for the longest period is considered the primary plan of coverage.
   f. Continuation coverage under the Consolidated Omnibus Budget Reconcilitation Act of 1985 (COBRA) always is secondary to other coverage, except as required by law.
   g. If the employee or dependent is confined to a *hospital* when first becoming covered under this plan, this plan is secondary to any plan already covering the employee or dependent for the eligible expenses related to that hospital admission. If the employee or dependent does not have other coverage for hospital and related expenses, this plan is primary.

Benefits under a Company-sponsored medical or dental plan are not coordinated with benefits paid under any other group plan offered by the Company. An employee can receive benefits from only one Company-sponsored medical or dental plan. However, when dental services performed by a licensed dentist also are covered under the medical plan, the dental plan pays its benefits first and the medical plan is secondary.

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan that covers a person as an active employee or dependent of an active employee. Medicare is primary in most other circumstances.

B. Traditional Medical Plan

The primary plan pays benefits without regard to any other plan. When the Traditional Medical Plan is secondary, it adjusts benefits so that the total payable under both plans for expenses covered under the Traditional Medical Plan is not more than would be payable under the Traditional Medical Plan. Neither plan pays more than it would without coordination of benefits.

"Plan" means any plan providing medical, dental, vision care, hearing aid benefits, or treatment under individual insurance, group insurance, or any other coverage for individuals in a group, whether on an insured or uninsured basis.

Treatment of end-stage renal disease is covered by the Traditional Medical Plan for the first 30 months following Medicare entitlement due to end-stage renal disease, and Medicare provides secondary coverage. After this 30-month period, Medicare provides primary coverage and the Traditional Medical Plan provides secondary coverage.

C. Network Dental Plan

Benefits payable under the Network Dental Plan take into account any coverage (including orthodontic coverage) the employee or family members have under other plans.

"Plan" means any plan providing medical, dental, vision care, hearing aid benefits, or treatment under group insurance or any other coverage for individuals in a group, whether on an insured or uninsured basis. However, plan excludes any medical plan sponsored by the Company. This means the Network Dental Plan pays first when dental expenses performed by a *dentist* also are covered by any medical plan sponsored by the Company.

The Network Dental Plan always pays regular benefits in full or a reduced amount which, when added to benefits payable by another plan, equals 100 percent of allowable expenses.

"Allowable expenses" means any *recognized fees* incurred during a year and while eligible for benefits under the Network Dental Plan, part or all of which would be covered under any plan.

No benefits are payable under this provision unless the charges were incurred in connection with a dental service or treatment.

Section 14. When an Injury or Illness Is Caused by the Negligence of Another

If a third party is legally liable for an injury or illness to a person covered under these medical and dental plans, regular plan benefits will be paid if the injured person agrees to cooperate with the service representative in administering the plan's subrogation rights. This includes providing all the necessary and requested information and submitting bills related to the injury or illness to any applicable insurer. The injured person must also agree to reimburse the plan if he or she recovers payment from the liable party or any other source. A third party includes any party possibly responsible for causing or compensating the injury or illness of a person covered under this plan, or the covered person's automobile, homeowner's, or other insurance coverage.

Section 15. Definitions

The following definitions apply to italicized terms in this document.

1. *Actively at work* means the employee is attending to his or her normal duties at the assigned place of employment. On a holiday, vacation day, weekend day, or other regularly scheduled day off, actively at work means the employee is not ill, injured, or otherwise disabled or confined to a *hospital* or similar institution, and is performing the normal activities of a person of his or her gender and age.
2. *Birthing center* means a facility for normal delivery operating under the direction and control of the licensing or regulatory agency in its location.
3. *Christian Science sanatorium* means a facility that, at the time of the healing treatment, is operated (or listed) and certified by the First Church of Christ, Scientist, in Boston, Massachusetts.
4. *Company-sponsored plan* means a group health care or dental plan approved by The Boeing Company or one of its subsidiaries or affiliates for its employees and dependents. This includes the Traditional Medical Plan and Network Dental Plan.
5. *Custodial care* means care that does not require the continuing services of skilled medical or health professionals and is primarily to assist patients in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications that are ordinarily self-administered.
6. *Dentist* means a legally qualified dentist practicing within the scope of his or her license. Under the Network Dental Plan, a network dentist is a licensed dentist who has agreed to the terms and conditions of a written PPO agreement with the service representative.
7. *Experimental or investigational service or supply* (Traditional Medical Plan) means a service or supply that meets at least one of the following criteria:

   a. It requires approval by the Food and Drug Administration or other government agency, which approval has not been granted when the service or supply is ordered.

   b. It has been classified by the national Blue Cross and BlueShield Association as experimental or investigational.

   c. It is under clinical investigation by health professionals.

   d. It is not generally recognized by the medical profession as tested and accepted medical practice.

   However, a service or supply will not be considered experimental or investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets each of the criteria in either Category 1 or 2 below.

   a. Category 1

      1) The trial has been approved by the National Institutes of Health, the Food and Drug Administration, the Department of Veterans Affairs, or a research center approved by the plan's service representative.

      2) The trial has been reviewed and approved by a qualified institutional review board.

      3) The facility and personnel have sufficient experience and training to provide the treatment or use the supplies.

b. Category 2

1) The trial is to treat a condition that is too rare to qualify for approval under Category 1.

2) The trial has been reviewed and approved by a qualified institutional review board.

3) The facility and personnel have sufficient experience and training to provide the treatment or use the supplies.

4) The available clinical or preclinical data provide reasonable expectation that the trial treatment will be at least as effective as noninvestigational therapy.

5) There is no therapy clearly superior to the trial treatment.

8. *Experimental service or supply* (Network Dental Plan) means a service or supply whose use and acceptance as a course of dental treatment for a specific condition are still under investigation or observation. To determine whether services are experimental, the plan, using American Dental Association guidelines, will consider if the services:

a. Are in general use in the local dental community.

b. Are under continued scientific testing and research.

c. Show a demonstrable benefit for a particular dental condition.

d. Are proven to be safe and effective.

9. *Home health aide* means an individual employed by a *home health care agency* or a *hospice agency* who provides, under the supervision of a registered nurse or *physical* or *speech therapist,* part-time or intermittent personal care, ambulation and exercise, household services essential to health care at home, and assistance with medications ordinarily self-administered; reports on changes in patients' conditions; and completes appropriate records.

10. *Home health care agency* means a public or private organization that administers and provides home health care, and is either Medicare certified or operating under the direction and control of the licensing or regulatory agency in its location.

11. *Home health (or hospice) care treatment plan* means a written program for continued care and treatment by the patient's attending *physician.* This plan must be reviewed and the continued need for care must be certified by a *physician* at least every two months.

12. *Hospice agency* means a public or private organization that administers and provides hospice care, and is either Medicare certified or operating under the direction and control of the licensing or regulatory agency in its location.

13. *Hospital* means an accredited institution licensed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a general hospital.

14. *Mail service prescription drug program* means a mail service prescription company approved by the service representative to provide services under an arrangement with the service representative.

15. *Medically necessary procedure, service, or supply* means one that, in the reasonable opinion of the service representative, meets the following criteria:

a. It is required to diagnose or treat the patient's condition and the condition could not have been diagnosed or treated without it.

b. It is consistent with the symptom or diagnosis and treatment of the condition.

c. It is the most appropriate service or supply essential to the patient's needs.

d. It is appropriate as good medical practice.

e. It is professionally and broadly accepted as the usual, customary, and effective means of diagnosing or treating the illness, injury, or condition.

f. When applied to an inpatient, it cannot safely be provided to the patient as an outpatient.

The fact that a procedure, service, or supply is furnished, prescribed, recommended, or approved by a *physician* does not, of itself, make it medically necessary. A proceudre, service, or supply may be medically necessary in part only.

16. *Mental illness* means a disorder (including an eating disorder) that exhibits symptomology, etiology, and features congruent with a Diagnostic and Statistic Manual of Mental Disorders IV diagnosis of mental disorder.

17. *Network* means a group of health care providers approved by the service representative as meeting criteria for efficient care delivery and performing services under a contract with the service representative.

    The service representative may designate certain health care providers and facilities as *network providers* for specific medical services through a "centers of excellence" program.

18. *Network provider* means a *physician, hospital,* or other health care provider who is a member of a *network.*

19. *Participating pharmacy* means a pharmacy that has an agreement with the service representative to accept payments in excess of the prescription drug copayment as payment in full for covered prescription costs.

20. *Physical therapist* or *occupational therapist* or *speech therapist* means a qualified physical, occupational, or speech therapist licensed in the jurisdiction where his or her services are rendered and practicing within the scope of that license. In locations without licensing requirements, the physical therapist must be certified by the American Physical Therapy Association, the occupational therapist must be certified by the American Occupational Therapy Association, and the speech therapist must be certified by the American Speech and Hearing Association.

21. *Physician* means only a physician who is licensed to prescribe and administer all drugs or to perform surgery. Physician also means the following health care professionals if they are licensed in the jurisdiction where they render services and are practicing within the scope of that license:

    a. Podiatrist.

    b. Psychologist.

    c. Optometrist.

    d. Chiropractor.

    e. Registered nurse (if services normally would have been performed by a *physician*).

    If a health care professional lawfully performs a service covered by this plan when performed by a physician and if applicable law requires recognition of this health care professional under this plan, the term physician will include the professional only to the extent required by law.

22. *Physician's assistant* means a person duly licensed in the area where his or her services are performed and practicing within the scope of such license.

23. *Plan administrator* means the Boeing Employee Benefit Plans Committee.

24. *Precertification* means prospective review and evaluation of proposed elective *hospital, substance abuse treatment facility,* and *skilled nursing facility* admissions as well as

home health and hospice care by qualified health care professionals. This evaluation, which uses accepted medical criteria to determine medical necessity and whether treatment could be given in a less intense setting, may include:

a. Length of stay review: A process that begins during precertification review in which medical professionals indicate the number of inpatient days medically appropriate for the proposed admission or certify medical necessity of the intensity or type of services received for home health or hospice care. Follow-up reassessments and extensions are made as medically warranted.

b. Concurrent review: Ongoing review while the patient is undergoing treatment in the *hospital*, or receiving care from a *home health care agency* or *hospice agency.*

c. Discharge planning: Discharge planning is designed to identify patients who could be discharged early if appropriate arrangements are made for covered alternative care.

d. Retrospective review: Retrospective review includes all the steps of precertification review, but after services are rendered. Retrospective review occurs when the medical review program (or *referral service* for the treatment of *mental illness* and *substance abuse*) is not contacted before treatment.

The role of the reviewing organization is to advise on medical appropriateness. The patient and *physician* decide on the treatment actually performed. Medical review affects payments under the Traditional Medical Plan as specified in Section 11.B.

25. *Principal support* means the employee continuously provides over 50 percent of the child's financial support and claims the child as a dependent on his or her federal income tax return. If unable to claim the child as a dependent for tax purposes because of a divorce settlement, the employee is considered to be providing principal support if the child resides with the employee or the employee has been issued a court order to provide substantial support.

26. *Prosthetic appliance* means a denture, partial denture, fixed or removable bridge, crown used as a bridge abutment, and other related items.

27. *Recognized fees* (Network Dental Plan) means the maximum fees recognized by the plan are the fees fixed by the *dentist* with Delta Dental. A member *dentist* may not charge more than these filed fees. A *network dentist* has agreed not to charge more than the *network* allowed charge. Nonmember *dentists* are paid the Delta Dental allowable fee.

28. *Referral service* means an organization that manages treatment of *mental illness* and *substance abuse* by contracting with providers of this treatment. The organization is responsible for:

a. Assessment of the patient's condition (including crisis intervention).

b. Referrals to *referral service providers.*

c. *Precertification* review of treatment for *mental illness, substance abuse*, and eating disorders.

d. Initial and ongoing review of provider treatment plans to assure services are *medically necessary* and given in the appropriate setting.

The referral service is considered the service representative for determining medical necessity of *mental illness* and *substance abuse.*

29. *Referral service provider* means a provider performing services under a contract with the *referral service* or a provider meeting *referral service* criteria for care to a designated patient.

30. *Skilled nursing facility* means an institution approved as such by Medicare.

31. *Substance abuse* means alcohol or drug dependence as classified in categories 303.0 to 304.9 of the most current edition of the *International Classification of Diseases, 9th Revision, Clinical Modification.*

32. *Substance abuse (alcoholism and/or drug abuse) treatment facility* means an institution providing treatment for chronic alcoholism and/or drug abuse and operating under the direction and control of the licensing or regulatory agency in its location.

33. *Totally disabled / total disability* (Life Insurance Plan) means all of the following conditions apply:

    a. The employee is disabled as a result of accidental injury or illness (including a pregnancy-related condition).

    b. During the first 30 months of disability, the accidental injury or illness prevents the employee from performing the material duties of his or her own occupation or other appropriate work the Company makes available.

    c. After the first 30 months, the disability prevents the employee from working at any reasonable occupation for which he or she may be fitted by training, education, or experience.

34. *Totally disabled / total disability* (Weekly Disability Plan) means all of the following conditions apply:

    a. The employee is disabled as a result of accidental injury or illness (including a pregnancy-related condition).

    b. The accidental injury or illness prevents the employee from performing the material duties of his or her own occupation or other appropriate work the Company makes available.

35. *Usual and customary* (Traditional Medical Plan), as determined by the service representative, is the lowest of these amounts:

    a. The provider's actual charge to the patient after any discounts or other reductions.

    b. The charge most frequently made by the provider to all other patients for comparable services or supplies.

    c. The charge most frequently made by providers with similar professional qualifications for comparable services or supplies in the same geographic area.

    d. In a network service area, the amount that would have been paid for like services or supplies to a provider who has a participating agreement with the service representative.

    The usual and customary charge for an unusual or complicated service will be evaluated by considering charges to treat illnesses or injuries of a comparable nature or complexity.

36. *Weekly base salary* (Weekly Disability Plan) means the employee's salary, including shift, lead, and foreign and domestic pay differentials, but excluding bonuses, overtime pay, cost-of-living allowances, incentive compensation, or other compensation the employee receives from the Company or a participating subsidiary. For part-time employees, benefits are determined using the average weekly salary actually earned for the six weeks immediately proceeding the disability date. If the employee has been employed by the Company for less than six weeks, the plan first figures the employee's pay as if he or she was full time; the weekly salary is that amount multiplied by a percentage equal to the employee's scheduled weekly hours divided by 40.

Section 16. Termination of Coverage

A. Weekly Disability Coverage

Weekly disability coverage ends on the date employment terminates.

B. Basic Life Insurance Coverage

Basic life insurance coverage ends on the date employment terminates except, if the employee's death occurs wthin 31 days, the life insurance benefit is payable.

Within 31 days after the employee terminates employment, by making application and paying the first premium to the service representative the employee may convert basic life insurance coverage to an individual life insurance policy on any regular whole life insurance plan. This individual policy will be issued, without medical examination and at the service representative's regular rates. The amount of basic life insurance converted cannot exceed the amount in force on the date insurance terminates.

If, after an individual conversion policy is issued, benefits under the Basic Life Insurance Plan are continued because of *total disability*, the individual policy must be surrendered without claim other than the return of paid premiums.

An employee who is being transferred and no longer is eligible for coverage under the Basic Life Insurance Plan, but who remains employed by the Company or one of its subsidiaries, also may convert the difference between the amount of life insurance provided by this plan less the amount provided by the plan for which the employee has become eligible. Application must be made within 31 days of the date of transfer.

C. Accidental Death and Dismemberment Coverage

Accidental death and dismemberment coverage ends on the date employment terminates.

D. Medical Coverage

Medical coverage for the employee and dependents ends at the end of the calendar month in which the employee terminates employment or the end of the last month required contributions are paid, whichever occurs first. If earlier, a dependent's coverage ends at the end of the month in which he or she no longer qualifies as a dependent.

However, coverage may be continued under certain circumstances as specified below. Any required contributions must be paid during these periods for coverage to continue.

1. In case of layoff, medical coverage for employees and dependents continues until the employee is covered by any other group medical plan either as an employee or as a dependent, but in no event beyond three months after the date of layoff.
2. If the employee dies (other than from an industrial accident), medical coverage continues for eligible dependents until the earlier of 12 months after the employee's death or when the dependents become covered by any other group medical plan.
3. If the employee dies from an industrial accident, medical coverage continues for eligible dependents until the earlier of 36 months after the employee's death or when the dependents become covered by any other group medical plan.

The service representative will make available to a terminating employee an individual program of medical benefits similar to those then being issued for group conversion. The benefits provided under the individual plan will not exactly duplicate the benefits provided under this group medical plan. This conversion privilege also is available to covered dependents who cease to qualify under the group policy and to surviving covered dependents if the employee dies. No evidence of insurability is required.

E. Dental Coverage

Dental coverage for the employee and dependents ends at the end of the calendar month in which the employee terminates employment. If earlier, a dependent's coverage ends at the end of the calendar month in which the dependent no longer qualifies as a dependent.

1. If the employee dies (other than from an industrial accident), dental coverage continues for eligible dependents until the earlier of 12 months after the employee's death or when the dependents become covered by any other group dental plan.
2. If the employee dies from an industrial accident, dental coverage continues for eligible dependents until the earlier of 36 months after the employee's death or when the dependents become covered by any other group dental plan.

F. Change in Eligible Class of Employment

When an employee remains employed by the Company but no longer is in the employee class eligible for coverage under this Package, coverage for the employee and dependents ends at the end of the month in which the employee's transfer is effective. If the employee becomes *totally disabled* before coverage ends under the Package, the basic life insurance, accidental death and dismemberment, and weekly disability benefits of the Package, which would have continued if the employee had stayed in the eligible class, will continue during the *total disability* instead of all other Company life insurance, accidental death and dismemberment, and weekly disability benefits.

G. Continuation of Medical and Dental Coverage (COBRA)

If medical and dental coverage for the employee and dependents otherwise would terminate because of one of the following reasons, these benefits may continue for specified periods under Public Law 99-272, Title X, as amended, if the individual makes a timely request to the Company and pays the required contribution.

1. Reduction in hours or termination of employment for any reason.
2. The employee's death.
3. The employee's divorce.
4. A dependent child ceasing to be a dependent as defined under this Package. (A child eligible to be continued under the Package's incapacitated child provision still will be considered to have dependent status.)
5. A dependent's loss of eligibility because the employee became eligible for Medicare.

Section 17. Leaves of Absence

When an employee is absent with leave, coverage may continue as follows; any required contributions must be paid during these periods for coverage to continue.

A. Approved Medical Leaves of Absence

An employee who is eligible for coverage and begins an approved medical leave of absence because of a *total disability* is eligible for the Package the same as an active employee until the last day of the calendar month in which the leave began. (Eligible dependents also are eligible for medical and dental benefits.)

If the employee is *totally disabled* and remains on an approved medical leave of absence that extends beyond this period, the employee's Package benefits (and dependent medical and dental benefits) continue up to six full consecutive calendar months during the approved medical leave. The Company will contribute its regular portion of the cost.

If the approved medical leave extends beyond this six-month period because of continuous *total disability*, the employee may continue basic life insurance coverage at no cost.

B. Other Approved Leaves of Absence

An employee who is eligible for coverage and begins an approved leave of absence is eligible for the package the same as an active employee until the last day of the calendar month in which the leave began. (Eligible dependents also are eligible for medical and dental benefits.)

If the approved leave extends beyond this time, the employee's weekly disaiblity, basic life insurance, accidental death and dismemberment, medical, and dental benefits (and dependent medical and dental benefits) continue for up to three full consecutive calendar months. The Company will contribute its regular portion of the cost.

C. Family and Medical Leave Act of 1993

If the required coverage for family and medical leaves of absence under the Family and Medical Leave Act of 1993 is more generous than that already provided in Section 17.A and Section 17.B, the Company provides any required additional coverage under its group health plans.

D. Uniformed Services Leave of Absence

If the employee takes a leave of absence for service in the U.S. uniformed services (including the military, National Guard, and the Commissioned Corps of the Public Health Service), he or she is covered under the package until the end of the month in which the leave began. If the employee remains on an approved leave of absence, coverage under the Package continues until the end of the third full calendar month of the leave as if the individual were an active employee on an approved nonmedical leave of absence.

If uniformed service extends beyond three months, the employee may continue medical and dental coverage under COBRA.

If the employee returns to active employment promptly after uniformed service, according to federal law, the package is reinstated on the date the employee returns to the active payroll.

E. Changes In Leave Types

For an employee changing directly from an approved nonmedical leave to an approved medical leave, or from an approved medical leave to an approved nonmedical leave, coverage provided with Company contributions under one type of leave reduces the coverage period provided with Company contributions through the other type of leave.

F. Successive Periods of Leaves of Absence

Two medical leaves of absence separated by fewer than 30 days of continuous work is considered one leave of absence unless the second leave is due to entirely unrelated conditions.